King County

Mental Health, Chemical Abuse and Dependency Services Division
Department of
Community and Human Services

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King County Mental Health Advisory Board (MHAB)
Regular Meeting
March 11, 2014

Members Present: Kristin Houser, Lauren Davis, John Holecek, Toni Krupski, Allan Panitch, Heather Spielvogle

Members Absent: Maria Davis, Alicia Glenwell, Katelyn Morgaine (excused); Nancy Dow, Veronica Kavanagh, Eleanor Owen (unexcused)

Guests Present: Joan Clement, King County Alcoholism and Substance Abuse Administration Board (KCASAAB) Liaison; Susan O'Patka (Ballard Ecumenical Ministries); Chami Arachchi, Kathy Obermeyer (Guests); Jeanne Slonecker (MH Ombuds)

Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Staff Present: Bryan Baird, Terry Crain, Jean Robertson

I. Welcome and Introductions

Toni Krupski, Chair, convened the meeting at 4:35 p.m., at the Chinook Building, 401 5th Avenue, Seattle, Conference Room 126. She welcomed the members and introductions were made by each person in attendance. A quorum was present for this meeting.

Guests, Chami Arachchi and Kathy Obermeyer, gave a brief introduction of themselves. Both are considering board membership.

II. Approval of Minutes

The January 14 and February 11, 2014 meeting minutes were approved unanimously.

III. Standards for Peer Support ~ Terry Crain

Terry reported the first King County peer support network meeting was in February; 30 employed peers attended where they discussed boundaries.

Another meeting is scheduled in March to discuss recovery language. A survey for the state was completed recently about peer services in King County. At the end of 2013, there were 131 peers employed throughout King County and the number continues to grow.

Terry then gave a presentation on practice protocols for peer support; a guide to increase understanding, reduce confusion, and provide a path to successful integration of peer supports. The ultimate goal is better outcomes for the people receiving services. Provider agencies that integrate peer support specialists into their workforces find that they have a heightened awareness of the struggles faced by the people they are serving.

Stigma is often reduced as negative attitudes toward people living with behavioral health challenges shift. Peer support specialists working alongside professional clinicians provide living proof that recovery is possible. This can raise morale by providing evidence to service providers that people are resilient and can and do recover. Peers' personal experiences can be a valuable asset to the clinical team. When they add their first-person knowledge and their stories of recovery to the service mix, services are enhanced and extended, as well as infused with hope and self-determination.

These protocols are universal requirements. Each of the 14 protocols includes a description and implementation guidelines. Several of the protocols touch on hiring practices and human resources (HR) issues. It will be important to share this work with agency HR staff and to work together toward implementation of each of the protocols in a manner that fits with agency policies, and in the context of all state, federal, and other regulatory guidelines. A number of these express policies and procedures (P&Ps) are usual and customary for all staff. Because some peers report their experience of agency employment differs from usual human resource P&Ps, these expectations are reiterated in the Protocols. Implementation guidelines are offered as suggestions for each Protocol and should be adapted to fit the unique needs of each agency or program.

This is a list of the 14 practice protocols:

1. Valuing the provision of peer support services in community mental health settings,
2. Integrating peer support specialists into the culture of each agency,
3. Providing peer support within teams and promoting their integration as valued team members,
4. Respecting shared experiences as the foundation of peer support,
5. Ensuring clear employment practices for peer counselors, including recruitment, job descriptions, orientation, and opportunities for advancement,
6. Ensuring equitable pay for peer support specialists,
7. Ensuring the provision of peer support specialist training and orientation to agency policy and procedures,

8. Supportive supervision practices for peer support staff,
9. Individualized support and reasonable accommodations for peer support staff,
10. Providing opportunities for professional growth and development,
11. Promoting ethical practice for peer support specialists,
12. Promoting understanding of the role of mutual support in the provision of peer support,
13. Promoting self-care for peer support staff, and
14. Fighting the stigma associated with mental illness.

These protocols became part of the MHCADSD P&Ps at the beginning of 2014. More documentation on these protocols can be found by visiting http://www.kingcounty.gov/healthservices/MentalHealth/Board/ArchivedMinutesandMeetingMaterials.aspx

IV. Chairperson's Report ~ Toni Krupski

To learn more through provider presentations at future MHAB meetings, Chair Krupski suggested the following as a guide for board consideration and discussion:

- Format—30 minutes total (15-20 minute presentation; 10-15 minute Q & A)

- Draft questions
  - Brief overview of program
  - Number of clients served
  - Agency successes/challenges, especially in:
    - Peer support services
    - Health care reform/working with the health care plans
    - Serving children/youth
    - Anything else?

- How can the provider voice be heard at the MHAB?

- How can the MHAB be helpful to these agencies?

Lauren Davis made these suggestions: the topic of co-occurring disorder services; provide more clarity on what the MHAB can offer; and inviting a provider who has not previously made contact with the MHAB; hear directly from consumers.

It was also suggested the Board include more helpful information on what the Board is about and the type of work done by the Board that would be helpful when inviting agencies to present. Other suggestions: request outcomes; client goals; alternating between a provider and consumer each month.

V. Committee Reports

Legislative Advocacy and Public Affairs Committee (LAPAC) Update
No report as this month's meeting was canceled.

Lauren Davis shared the massive win for suicide prevention training legislation. She noted it passed in the House 94 to three, and passed in the Senate 49 to zero. The Bill is now on its way to Governor Inslee and will require 140,000 medical professionals in Washington to have a one-time training on suicide prevention. Washington is the first state in country to do this.

Membership Committee
Chair Krupski noted Alicia Glenwell plans to have a Membership Committee meeting this month to review the proposed bylaw changes by section and other committee work around attendance, the application for Board membership, the onboarding process, etc. A report will be made at the April MHAB meeting.

Quality Council (QC) Update
No report. Meeting was canceled.

Recovery Advisory Committee (RAC) Update
No report.

Mental Illness and Drug Dependency (MIDD) Oversight Committee (OC) Update
No report.

VI. Staff Report – Jean Robertson

Jean gave the following updates:

- **Bills**
  There are two Bills, House Bill 2639 and Senate Bill 6312, being worked on that moves the mental health and substance use systems toward integration. There are challenges with full integration with behavioral healthcare and primary healthcare, but there are questions on how prescriptive the Bills should be about how we get there and the timelines for accomplishing this.

  The goal of this work is driving the system toward full integration, doing away with separate mental health and substance use contract—one contract used for the delivery of all services.

  The integration bill will move the County away from fee for service contracting to an integrated, managed care capitated system on the substance use side, just like the mental health side. The County is in support of this effort.

  These bills also call regional service areas and changing the name from Regional Support Networks (RSNs) to Behavioral Health Recovery

Organizations. There is still discussion of the number of RSNs: one Bill allows for staying at 11, another proposes that only nine RSNs are needed. The development of these Behavioral Health Recovery Organizations would become the entity that manages the behavioral health systems. By the time full integration is achieved, presumably the healthy options plans could choose to contract with those organizations.

- **Budget**
  News is not great for the substance abuse side; they are likely looking at cuts, but one unexpected outcome is that King County will be funding another Program of Assertive Community Treatment (PACT) team, which was not requested by King County. King County lobbyists have proposed new language to address this issue such as providing intensive community service to reduce hospitalization and lengths of stay. They are also prescribing that King County open a 16-bed facility, albeit sufficient funds are not being made available to accomplish this.

VII. Quarterly Liaison Reports

Vice Chair Houser met with Children's Hospital (CH) mental health program representatives in February and reported there are oddities in the reporting requirement between the agency and King County they would like to discuss. The CH is in the process of opening a new inpatient facility (doubling the size of the existing facility) that will take another year to complete.

Also, she reported the University of Washington (UW) clinics have a mental health provider with access to a backup psychiatrist in nine of their 13 clinics with plans to roll this model out to rest of the clinics. The UW is trying to get support from CH to provide the backup psychiatrist; a difficult hurdle.

VIII. Board and Community Concerns

Joan Clement announced Linda Brown has resigned from the KCASAAB and noted that she has been a wonderful contributor to the MHAB and MIDD as well. Linda will be sorely missed. Joan will continue being the KCASAAB liaison.

Joan also noted the Medicaid rate is significantly lower than the non-Medicaid rate for substance abuse and requested the email be forwarded to the MHAB requesting members to call their representatives and ask for the Medicaid rate to be increased. As more people are covered by Medicaid under expansion, agencies are losing large sums of money and cannot stay open if this continues. She advised each MHAB member to please call their legislators.

IX. Adjournment

There being no further business, the meeting adjourned at 6:10 p.m.

Prepared by: **Attested by:**

Bryan Baird, Board Liaison

Toni Krupski, Chair